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AUTHOR Desselle, Maxine
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ABSTRACT

This practicum sought to reduce the number of inappropriate referrals to a rural school system's Special Education Department from the private sector, by increasing the private sector's knowledge of eligibility criteria for learning disability services. A school social worker conducted individualized consultations with clinicians in the private sector throughout the county, and a pamphlet describing the distinction between learning disabilities and attention deficit disorder was provided. The 32 clinicians exhibited mastery of the content when assessed by a 10-item instrument measuring knowledge of criteria for learning disability services. Results concerning reduction of the number of inappropriate referrals were inconclusive. Appendices contain a referral form, eligibility requirements for learning disability and attention deficit disorder, a copy of the assessment instrument, a copy of the pamphlet, and other materials. (Approximately 50 references) (JDD)

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Bridging the Communication Gap between the Private Sector and Special Education through Consultation Strategies Regarding Latency-Aged Children Diagnosed Attention Deficit Disorder

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by

Maxine Desselle

Cluster XXXI

A Practicum II Report Presented to the
Ed.D. Program in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1990

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PRACTICUM APPROVAL SHEET

This practicum took place as described.

Verifier: Aaron Washington
Aaron Washington

Director of Special Education
Title

Opelousas, Louisiana
Address

August 14, 1990
Date

This practicum report was submitted by Maxine Desselle under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Early and Middle Childhood and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

August 14, 1990
Date of Final Approval of Report

JoEllen Salce Rogers, Ph.D.
Advisor

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ABSTRACT

Bridging the Communication Gap between the Private Sector and Special Education through Consultation Strategies Regarding Latency-Aged Children Diagnosed Attention Deficit Disorder. Desselle, Maxine, 1990: Practicum Report, Nova University, Ed.D. Program in Early and Middle Childhood. Descriptors: Special Education/Attention Deficit Disorder/Learning Disabilities/ Learning Disabled/Private Sector/ Private Evaluations/Criteria/ Elementary Education/Latency-Aged/Psychological Testing/ Pediatricians/Assessment Instruments/Diagnosis/Recommendations.

This practicum was designed to (1) reduce the number of inappropriate evaluations and recommendations to the Special Education Department from the private sector, and (2) increase the private sector's knowledge regarding criteria for Learning Disabled services. The literature indicated the difficulties in distinguishing characteristics for an Attention Deficit Disordered child and a Leanring Disabled child for proper referral by the private sector. This practicum was aimed at increasing the private sector's knowledge regarding criteria for Learning Disabled, thereby reducing inappropriate referrals.

The writer provided individualized consultations with clinicians in the private sector throughout the county. Scheduled individualized consultations allowed for intensive feedback by all participants. A pamphlet that describes the distinction between Learning Disabled and Attention Deficit Disorder and the criteria for eligibility for Learning Disabled services was also provided at the time of the consultations.

The data indicate that the objectives were met. Clinicians in the private sector demonstrated an increased knowledge regarding criteria for Learning Disabled and deficits associated with Learning Disabled. Implications are that the private sector is aware that they must communicate with the Special Education Department in order to meet the needs of children with learning difficulties. Through this practicum, the private sector and the Special Education Department appear to have bridged the communication gap.

CHAPTER I

INTRODUCTION

Description of Work Setting and Community

This practicum was conducted in one of the state's largest public school systems that covers a radius of 155 miles. There is a population of 17,000 in 29 elementary school, 4 junior high schools and 12 high schools with 459 elementary teachers and 396 secondary teachers. Of the 2,162 students receiving special education services, 304 are Learning Disabled. There are 32 clinicians in the private sector that have diagnosed 270 children as Attention Deficit Disorder.

The general population of the area in which this practicum was conducted is 86,695 as of 1988. The population is 62 persent white of French and Italian background and 38 percent black with an equal distribution of Catholics, Baptists, Pentecostals, Methodists and Jehovah's Witnesses. The population of Latency-Aged children is 8,472.

The socioeconomic makeup of the community ranges from low to middle with a median income of $19,100. Approximately 17.0 percent of the residents receive public assistance and live in public housing projects in this area. A large percentage of the people in this area are small farmers of soybeans, corn and sweet potatoes. Approximately 17.2

percent of the population are unemployed.

Most of the general population is serviced by the public school system, however there are 10 private/parochial schools located in this area that service 2,796 students.

Writer's Work Setting and Role

The writer's work setting is the Department of Special Education - Pupil Appraisal Services located in a rural area. the writer secured permission from the Department to utilize the forms necessary for this practicum (see Appendix A).

Uniqueness of the work setting can be described as a multidisciplinary diagnostic team that involves cross-cutting of the disciplines at the pupil appraisal assessment phase of the evaluation. Population of the staff is 20, including 8 assessment teachers, 6 psychologists, 4 social workers, 1 audiologist, 1 occupational therapist, 2 coordinators and 1 director. Speech therapists and adaptive physical therapists are assigned as needed.

The writer's role in the work setting is school social worker. Qualifications for the position are a two year master's degree in social work with two year's supervision on the job setting followed by an examination to fulfill license requirements (see Appendix B). The writer is certified by the state as a Board Certified Social Worker and nationally by the Academy of Certified Social Workers.

Responsibilities include acting as a liaison person

between designated schools and the special education department. Specific responsibilities of the liaison person include screening referrals and evaluation from the private sector for special education services. A teacher, parent or a principal can initiate a referral.

The referral consists of the student's demographic data, referral concerns, a review of the student's academic data and social performances, current attendance data, language and communication skills, performance on applicable statewide assessment and basic skills tests, motor proficiency conducted by the teacher, and documented parent/teacher communication relevant to the referral concern, and any other pertinent information (see Appendix C).

Along with screening referral forms, the writer also coordinates cases for diagnostic evaluations and re-evaluations. As coordinator, the writer is required to follow specific procedures within a designated time frame required by the state department in order to comply with Public Law 94-142 (see Appendix D).

Specific duties as a social worker include conducting parent social interviews in order to compile social histories, administering specific adaptive instrument to parents, directing support services to students with learning or behavior problems, crisis intervention and providing in-service training on selected topics to school personnel.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

The problem was that the private sector -- clinicians such as psychiatrists, psychologists and pediatricians -- make inappropriate recommendations for special education services. The time and money wasted on inappropriate referrals impede the Special Education Department. Thus, the needs of the child who does not meet criteria for eligibility were not being met in the regular classroom or in the home.

The problem existed because the private sector was evaluating, diagnosing and recommending Attention Deficit Disordered children with and without hyperactivity for Learning Disabled services. The private sector was unaware of the eligibility requirements for special education services for the exceptionality of Learning Disabled. As a result, many referral concerns and evaluations are indicative of behaviors and symptoms unique to the Attention Deficit Disordered child rather than the Learning Disabled child. Moreover, the private sector did not have a clear understanding of the definition of Exceptionality (see Appendix E).

Many students referred for Learning Disabled services are in fact classified as no exceptionality after a diagnostic

evaluation conducted by the pupil appraisal services are not eligible for special education services. This created confusion and disagreement with the diagnostic findings by the private sector and parents, thus generating a communication gap between the private sector and the special education department. The majority of these students range from five to twelve years of age (Latency-Aged children).

Problem Documentation

In the writer's area there are 32 clinicians who have diagnosed a total of 270 Attention Deficit Disordered children with implication for Learning Disabled services during the 1987-88 academic school year. Available data indicate that 707 new referrals were made and 270 of these address Attention Deficit Disorder characteristics.

TABLE I - Referrals and Eligibility

	1987-88 School Year
Number Referred	707
Number with ADD Characteristics	270
Number with LD Characteristics	187
Number with non ADD/LD Problems	250

Moreover, the writer acquired a type of newsletter that has been distributed within the area regarding Attention Deficit Disorder and Learning Disability. This document

compounds the confusion between Attention Deficit Disorder, Learning Disability and Learning Disabled. The authors describe the characteristics and the treatment of Attention Deficit Disorder and Learning Disabled as one and the same (see Appendix F).

Causative Analysis

The documented data indicate the confusion within the private sector with the terminology of Learning Disabled, Learning Disabilities and Attention Deficit Disorder with and without hyperactivity. There was also confusion in the private sector over eligibility requirements for Learning Disabled services as outline in the state's Bulletin 1508 (1983) guidelines. The private sector was unaware of the diagnostic criteria for Learning Disabled in order for a child to receive special education services as outlined in Public Law 94-142 (see Appendix G). This confusion affected the parents of Attention Deficit Disordered children regarding special education services.

Specifically, Attention Deficit Disorder is not an exceptionality and does not meet criteria required for special services. Attention Deficit Disorder is a type of Learning Disability but not a criterion for classification of Learning Disabled. Also, only Attention Deficit Disorder is outlined in the Diagnostic Statistical Manual III-Reviced (1986) (see Appendix H). An Attention Deficit Disordered child exhibits

behaviors such as hyperactivity, impulsivity and inattention that are associated with Learning Disabled and affect academic performance. However these characteristics are not utilized as criteria for diagnostic purposes. For example, daydreaming, inattentiveness, being easily distracted or overly active do not constitute a proper referral for Learning Disabled if the child does not exhibit specific academic deficits in a specific area.

Relationships of the Problem to the Literature

Definition of the exceptionality Learning Disabled as outlined in Bulletin 1508 of the Department of Special Education (1983) includes terms such as attentional deficit, perceptual handicaps, process disorders, minimal brain dysfunction, brain injury, dyslexia, developmental aphasia or sensory-motor dysfunction. However, to be classified as Learning Disabled, a student must exhibit an academic deficit in one of the following areas: reading recognition, reading comprehension, math calculation, math reasoning, oral expression, listening comprehension and written expression (spelling). Also, there must be a discrepancy between achievement as measured by the Woodcock-Johnson Psycho-educational Battery and ability as measured by the Wechsler Intelligence Scale for Children - Revised (WISC-R) (see Appendix F).

Confusion lies in the definition of Learning Disabled by the State Department that includes terms that also apply to

Attention Deficit Disorder, but those terms alone are not used for eligibility requirements.

Gerardi and Coolidge (1983) report that behavior problems were the primary reason for referral for children suspected of Learning Disability. Hayden, Smith, Hippel and Baer (1986) acknowledged teachers' reports that the child is like a "walking radar set." The child is constantly distracted by all the sights, sounds and events in the environment, and unable to block out things that are unimportant. Draeger (1987) reports that Attention Deficit Disordered children exhibit an application deficit rather than the ability deficit unique to Learning Disabled as a major contributor to poor classroom performance. This coincides with the definition outlined in the writer's state guidelines, which is an ability deficit for Learning Disabled rather than an application deficit.

Dalby (1985) compared children with Attention Deficit Disorder and children with reading disorders (Learning Disabled). He found Learning Disabled children were more impaired in academic attainment and showed evidence of qualitative disturbance in reading and spelling. He found that Attention Deficit Disordered children showed no qualitative reading or spelling problems. Copeland (1981) also stated that Attention Deficit Disordered children consistently have more difficulty with tasks of memory and attention than do Learning Disabled children.

Metzger and Freund (1986) report that the hyperactive child is more sensitive to external contingencies while the Learning Disabled child is more sensitive to instructions. Accordingly, Conte and others (1984) state that Attention Deficit Disordered children exhibit deficits in sustaining attention, whereas the Learning Disabled child exhibits deficits in selective attention.

The literature indicates the difficulties in distinguishing characteristics of an Attention Deficit Disordered child and a Learning Disabled child for proper referral. The confusion is complicated by the fact that a Learning Disabled child may be impulsive and hyperactive, but the primary disorder is psychological processing that affects learning. An Attention Deficit Disordered child exhibits behaviors such as hyperactivity, impulsivity and inattention that is associated with Learning Disabled and affects academic performance. So the clinician has to determine what comes first "the egg or the chicken." Specifically, Thurlow, Ysseldybe, and Cassey (1984) report on the ambiguity of identifying criteria and disagreement among referring teachers regarding the definition of Learning Disabled.

Graden (1986) reported the national figures indicate that of 92 percent of the student population referred for an evaluation, 83 percent are found to be eligible for services. These figures indicate that 19 percent of the student population

who exhibited difficulties with academic performance are not eligible for special services. These figures support the data collected by the writer.

An approach to determine whether a child has a Learning Disability is not a simple task, according to Sattler (1988). Public Law 94-142 outlines specific guidelines for determining the existance of a specific learning disability. Specifically, a child must have an ability-achievement discrepancy. Sattler (1988) continues to report on the diagnostic difficulties with Attention Deficit Disorder. Usually children who are referred for an evaluation are those that are normal but come from less tolerant environments. Assessment of Attention Deficit Disorder centers on the inability to focus, sustain and organize attention and the inherent impulsive responding. Assessment of the above often relies on rating scales.

To a large extent, Popper (1987) states that a diagnosis of Attention Deficit Disorder is based on clinical judgment. Children with Attention Deficit Disorder are prone to learning problems, but the kind of problems Attention Deficit Disordered children display are very different from other kinds of learning disabilities. Often their learning deficiencies are not as severe or as clear-cut as those of Learning Disabled children. To make the matter more complicated, these children are diagnosed by clinicians as Learning Disabled and are recommended for special education services.

Batshaw and Perret (1986) state that unfortunately no test exists that specifically diagnoses Attention Deficit Disorder with or without hyperactivity. Brain wave tests, called electroencephalograms (EEG's) are mildly abnormal in about half of these children. Lubar (1985) emphasized the use of neurometric techniques for screening of learning disabilities. The EEG, according to Lubar (1985), provides a solid foundation for helping children with Attention Deficit Disorder.

A discrepancy between verbal and visual-perceptual performance is usually displayed through psychological testing. Educational Assessments may reveal evidence of attentional deficits that may interfere with learning. Batshaw and Perret (1986) contend that diagnosis of Attention Deficit disorder relies on the exclusion of the other diagnoses such as soft neurological signs, symptoms of attention deficit such as impulsivity and hyperactivity. Batshaw and Perret (1986) further contend that an accurate diagnosis is ultimate for adequate treatment of Attention Deficit Disorder.

According to Sinclair (1981), who investigated the relationship between diagnostic classifications and educational placement, there is a lack of clinical consensus.

In the October issue of News Digest (1985), Wodrich (1984) discusses assessment as it relates to Learning Disabled Latency-Aged children. He reports that Learning Disabled children have

disabilities in specific areas such as reading, writing or arithmetic and because of these disabilities have lower achievement records than would be expected from their overall intelligence quotient (IQ) score. He further state that an intelligence measure such as the Wechsler Intelligence Scale for Children-Revised, that measures overall information about specific abilities along with an individual's academic achievement test, should be administered to school age children.

Further information about diagnosing Learning Disabilities is available in the National Information Center for Handicapped Children and Youth News Digest (1985).

In a survey of 307 research studies, Kavale and Nye (1981) concluded that little consensus exists regarding identification criteria for Attention Deficit Disorder. Problems do exist; however, there are guidelines within the legal definition for determining whether a child is Leanring Disabled. In diagnosing Learning Disabled both formal and informal assessment must be used to obtain a balanced view of the child's actual and potential achievement. Standardized tests, such as the Wechsler Intelligence Scale for Children - Revised and the Peabody Picture Vocabulary Test, are used for formal assessment. Informal assessment involves carefully observing a child's total behavior while he or she performs tasks in a natural setting. Murry (1981) emphasis the use of standard psychological tests and he also discusses clinical nonstandard

procedures as adjuncts to the traditional measures.

In order to provide distinction between Learning Disabled and Attention Deficit Disorder, Bauermeister (1987) developed an inventory for the assessment of children who may demonstrate those characteristics. Also, Leton (1987) reports that classification of children with learning disabilities can be divided into 3 clusters: (1) attention and concentration (2) verbal association intelligence and (3) visual spatial and motoric. In the writer's professional judgment that first cluster is unique to Attention Deficit Disorder and cannot stand alone for classification purposes of Learning Disabled.

One case study conducted by Heubner (1981) regarding specific and nonspecific referrals indicates that 82 psychologists made referrals based on test data on learning disabilities. These psychologists made referral decisions based on educational along with psychological data. Still another study conducted by Moore (1984) indicates that psychological assessments were primarily used for diagnosing Learning Disabled children. These psychologists probably had no specific guidelines or criteria on which to base their decisions.

Without a guideline for diagnosis, discrepancies will evolve among clinicians. Fram (1982) reports on the interclinician agreement and bias among psychologists' diagnoses for a Learning Disabled child. Also Epps (1982)

reports on the interjudge agreement in classifying students as Learning Disabled among clinicians. Specifically Epps (1982) found that clinicians were extremely inaccurate and that different clinicians emphasized different factors for diagnostic purposes. Epps (1982) also conducted a study regarding the difficulty with differentiating Learning Disabled from non-Learning Disabled students. Clinicians' results indicate that a battery of tests does not increase the decision maker's ability to discriminate between Learning Disabled and non-Learning Disabled students. This author recommends that current assessment practices be simplified. This writer disagrees with the above author. Simplification is not the answer, but rather a standard set forth in a guideline that will serve as the "Bible" for diagnostic purposes.

Kalechstein (1980) conducted a survey of pediatricians' and special education teacher's perspectives regarding Learning Disabled. Results indicate little agreement on variables for diagnosis. Hynd (1982) suggests that school psychologists reevaluate their concepts regarding the child with learning problems.

Lentz (1984) reports that not all referred problems are a result of skill deficits but rather performance deficits. This supports the writer's concern, that more referrals are indicative of performance deficits such as "off task," "talking out of turn," and "out of seat" which are characteristics of Attention Deficit Disorder.

A study conducted by Mehan (1981) suggests that school districts should be organized to implement standard practices rather than make systematic choices from a range of alternatives for diagnostic and placement purposes.

Scott (1987) reports on the criteria used by the American Psychiatric ASsociation in diagnosing Attention Deficit Disorder. The criteria for Attention Deficit Disorder is interchangeably used with the criteria for Learning Disabled.

Objective and reliable techniques for assessment of Attention Deficit Disorder have remained largely unavailable to psychoeducators and pediatricians. Consequently Gordon and McClure (1983) report that these clinicians have based their evaluation solely on observation, teachers' reports or on the Wechsler scales. Also, clinicians must consider that Attention Deficit Disorder and Learning Disabled children exhibit deficits with sustained attention; however, only Learning Disabled children exhibit deficits with selective attention that must be assessed.

Many instruments have been utilized to identify and assess Attention Deficit Disorder. However, in a study conducted by Zarski (1987) validity questions were raised regarding the Wisconsin Card Sorting Test, Canter Background Interference Procedure for the Bender-Visual Motor Gestalt Test, Conners' Parent Questionnaire and three measures of the Wechsler Intelligence Scale for Children-Revised for identifying Attention Deficit Disorder.

Subjectivity is a variable that must be addressed with any instrument used for assessment. Vivian (1985) evaluated the effect of the label hyperactive with psychologists and pediatricians who recommended various assessment and intervention for a child who displayed symptoms of hyperactivity. Results indicate that certain procedures and treatment are influenced by the label hyperactivity.

The literature covers 33 recent empirical articles and studies related to the writer's problem. The literature justified the theoretical and practical importance of this problem. Specifically, several disciplines, including medicine, social work, psychology and education describe the assessment and diagnostic difficulties with Attention Deficit Disorder. An analysis of the literature indicates that Attention Deficit Disorder is often diagnosed as secondary to other learning difficulties that include Learning Disabled.

As stated in the literature, Public Law 94-142 provides specific guidelines for diagnosis of Learning Disabled, however no specific guidelines are provided for Attention Deficit Disorder in this law. The dilemma was that, because there are no guidelines for Attention Deficit Disorder, clinicians in the private section continue to make statements that might lead parents to believe that their child is Learning Disabled and eligible for special education services.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

The goals of this practicum were to (1) reduce the number of inappropriate evaluations and recommendations to the Special Education Department from the private sector during the 1989-90 academic school year, and (2) increase the private sector's knowledge regarding criteria for Learning Disabled services. Expectations included more appropriate evaluations and recommendations from the private sector and an awareness of the diagnostic tools utilized by the state for classification purposes. Specifically, clinicians in the private sector were to recognize characteristics unique to Learning Disabled and be able to differentiate between Learning Difficulties, Learning Disabled and Attention Deficit Disorder.

Behavioral Objectives

The following objectives were projected for the practicum.

Objective 1: The 32 clinicians from the private sector will demonstrate an increased knowledge regarding criteria for Learning Disabled by responding correctly to 8 out of 10 items on the Special Education Assessment Instrument by the end of

eight months.

Objective 2: the 32 clinicians will decrease the number of inappropriate referrals by their evaluation and recommendations meeting 80 percent of the criteria on the Evaluation Review Instrument at the end of eight months.

Measurement of Objectives

The following instruments were developed by the writer utilizing specific criteria for assessment of children with Learning Disabilities that the writer has observed in her professional setting and in the literature review.

Objective 1 was measured by the Special Education Assessment Instrument (see Appendix H). This instrument lists items that are used to classify children with a Learning Disabled profile. Items include the communication, academic and social categories. Items that are not utilized as criteria for Learning Disabled eligibility were also included.

Objective 2 - The Evaluation Review Instrument (see Appendix I) was developed to measure the second objective. This instrument lists criteria an evaluation must meet in order for the student to be eligible for Learning Disabled services. Also, this instrument lists deficiencies in an evaluation that prevent compliance with Bulletin 1508.

The Special Education Assessment Instrument was utilized during the implementation stage. The Evaluation

Review Instrument was developed to be used at the end of the eight month period in order to assess the quality of the evaluations and quantity of recommendations generated from the clinicians.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Possible Solutions

The literature outlines several solutions the writer may draw from in order to reduce the number of inappropriate evaluation and recommendations from the private sector.

Silver (1987) states that the first step in solution strategy for increased awareness is for all aspects of Attention Deficit Disorder and Learning Disabled to be recognized by the private sector.

In order to improve the Special Education delivery system, Mirsky (1988) implemented consultation strategies with the target audience. Guidelines were provided and a brochure that described services available was distributed.

News Digest (1985) issued three newsletters that focus on Learning Disability issues in order to increase the public's understanding. The first newsletter provided an overview of Learning Disability with criteria for diagnosis. The second newsletter focused on psychological testing. The third issue of the newsletter presented guidelines to help parents find information and services.

Shapiro (1987) viewed consultation with teachers as the most effective means of implementing suggested interventions.

In-service training conducted by Truskin (1985) regarding eligibility requirements for specific Learning Disability reduced inappropriate referrals by 50 percent.

To increase the referral system of all eligible special education students Goldberg (1988) provided multimedia in-service training.

Recent research by Spencer (1988) demonstrated increased knowledge of teachers by providing in-service training regarding eligibility requirements.

Recognizing that a problem existed with the private sector Hobson (1987) described a training program with the staff and practitioners. Also, Dickinson (1985) utilized consultation activities conducted with a small investment of time that met with a high degree of accomplished objectives.

Consultative services were also utilized by Chandler (1981) to demonstrate alternative methods for providing psychoeducational services. This strategy met with success in reducing inappropriate referrals.

Book (1984) developed a guide for practitioners regarding testing, intervention and placement. Franchak (1984) also developed a handbook designed to serve as a resource with the target audience of administrators, teachers, and practitioners.

Specific techniques are also outlined in the literature to provide clinicians diagnostic assistance. Keuhne (1987) investigated the power of five measures to differentiate

between children with Attention Deficit Disorder and Learning Disabled. Cruickshank (1985) conducted studies in educational evaluations. Suggestions were given for psychological diagnosis and educational programs to meet the needs of the Learning Disabled children. In this writer's opinion, clinicians also need suggestions for psychological diagnosis and educational programing to meet the needs of the Attention Deficit Disordered children.

A technique that could be used for diagnostic assistance is the Ozawa Behavioral Rating Scale for assessing Attention Deficit Disorder proposed by Ozawa and Michael (1984). This instrument may also be appropriate for identifying Learning Disabled children

Evaluation of the possible solutions suggested in the literature indicate overall positive results with in-service training and consultative strategies. Specific techniques were suggested to decrease inappropriate referral and provide diagnostic assistance to clinicians in the private sector. These techniques include brochures, newsletters, guidebooks and handbooks.

In the writer's opinion, all of these techniques have achieved positive results and appear workable in the designated population and can be easily implemented in the writer's work setting.

Report of Action Taken

The literature provided strategies the writer drew from, utilizing several techniques to reduce inappropriate evaluations and recommendations from the private sector. In considering the results obtained by the authors, the writer believes that in-service training would be beneficial in reducing inappropriate recommendations for Learning Disabled services. Furthermore, in analyzing the literature review, the writer believes that one-on-one consultations along with a brochure would be most effective in reaching the goals.

Specifically, Mirshy's (1988) consultation strategies and a brochure that described services available met with success. News Digest (1985) reports on the three newsletters focusing on Learning Disabled services that proved to be successful. Also Shapiro (1987) viewed consultation as most effective in implementing suggested interventions.

This writer believes that the consultation strategy along with a pamphlet that describes the difference between Attention Deficit Disorder and Learning Disabled and the criteria for eligibility for Learning Disabled services worked to solve the problem (see Appendix J).

This writer conferred with clinicians on an individual basis in order to bridge the communication gap regarding Attention Deficit Disorder and Learning Disabled. Personalized meetings ensured successful communication and

a comprehensive understanding by the clinician of his/her role in the diagnostic and recommendation process.

The writer developed a pamphlet that focuses on criteria for Learning Disabled services, Attention Deficit Disorder, and Hyperactivity. The pamphlet lists services available under each disability. The pamphlet was distributed among the clinicians and an ample supply was provided for them to distribute among their clients.

Because of the ethical consideration regarding confidentiality, this writer was unable to provide a sample assessment and evaluation for the clinicians to review and keep at their disposal.

The projected time line was eight months. The first month of the implementation the writer scheduled appointments by telephone to meet with the clinicians throughout the county. Initially the writer had planned to schedule appointments with the clinicians in the northern part of the county during the first month, however this was not feasible because some of the clinicians' appointment books were filled for December. Specifically, December, January, February and March were difficult months to schedule appointment with the pediatricians because of an epidemic of influenza. Several pediatricians had their nurses call the writer to reschedule their appointments. Therefore the writer utilized the month of December to schedule and reschedule appointments with the

13 clinicians in the northers part of the county, the 8 clinicians in the western part of the county, and the 11 clinicians in the southern part of the county. Scheduled appointments ranged from January to May.

The writer had planned to collect the Special Education Assessment Instruments from the clinicians during the fourth, fifth and sixth months and clear up any misconceptions. However, due to the difficulty of scheduling, the writer performed all tasks during the initial visit. These individualized visits allowed for in-depth verbal intercourse and, because of interest, some visits went over the allotted time. Because of the deep involvement of the clinicians in the individual consultations, misconceptions were easily addressed while the clinicians answered the questions on the Assessment Instrument. One return visit was necessary because of an emergency with a patient that occurred at the time of the appointed consultation.

The clinicians were grateful for the pamphlets and informed the writer that this kind of information was long over-due. The clinicians were informed that additional pamphlets will be provided upon request. One pediatrician requested that the writer conduct a workshop for parents of his clients with Learning Difficulties. The writer at this point developed a flier concerning a workshop for the pediatrician to distribute among parents in order to generate

participation (see Appendix K). Also, another clinician suggested that workshops for private schools and service clubs, such as Sertoma and Lions, would be beneficial in reading an interested bu thus far overlooked audience.

The writer anticipates that workshops for the private sector and parents will be ongoing.

Calendar Plan

November 20, 1989	Secured approval for Proposal.
December, 1989 Weeks 1, 2, 3, and 4.	Scheduled appointments with clinicians in the county.
January, 1990 Weeks 5, 6, 7, and 8.	Conferred with clinicians in the western part of the county (5).
February Weeks 9, 10, 11, and 12.	Conferred with clinicians in the northern part of the county (6). Return visit scheduled (1).
March Weeks 13, 14, 15, and 16.	Conferred with clinicians in the northern (5) and western (3) part of the county.
April Weeks 17, 18, 19, and 20.	Conferred with clinicians in the northern (2) southern (8) part of the county. Made return visit.

Progress Report to Advisor

May Weeks 21, 22, 23, and 24.	Conferred with remaining clinicians in the southern part of the county (3).
June and July Weeks 25 to 32	Compiled evaluation data. Phone conference with Advisor.
August	Submitted report to Advisor
October	Disseminated abstract to Cluster 31 members. Report disseminated to the Director of Special Education.

CHAPTER V

RESULTS, CONCLUSIONS, RECOMMENDATIONS AND DISSEMINATION

Results

The goals of this practicum were to (1) reduce the number of inappropriate evaluations and recommendations to the Special Education Department from the private sector, and (2) increase the private sector's knowledge regarding criteria for Learning Disabled services.

A series of in-depth consultations with clinicians in the private sector were conducted over an eighth month period. A pamphlet that describes the difference between Learning Disabled and Attention Deficit Disorder along with the criteria for eligibility for Learning Disabled services was also provided at the time of the consultations.

Objective I, as stated in Chapter III, projected for the 32 clinicians from the private sector to demonstrate an increased knowledge regarding criteria for Learning Disabled by responding correctly to 8 out of 10 items on the Special Education Assessment Instrument. The information compiled from the Special Education Assessment Instrument for Learning Disabled indicated a mastery level of 81 percent. Twenty-six out of the 32 clinicians responded correctly to items on the instrument. Specifically, all clinicians demonstrated confusion with Item 3: "Poor oral expression," Item 7:

"Dyslexia," and Item 8: "Inability to focus, sustain and organize attention." However six clinicians responded incorrectly regarding whether Items 3, 7 and 8 were criteria for Learning Disabled or deficits associated with Learning Disabled. Table 2 indicates that most of the clinicians did master a knowledge regarding criteria for Learning Disabled. Table 3 depicts the frequency of correct and incorrect responses to each item.

Table 2

Clinicians' Knowledge of Criteria for Learning Disabled

Total Number of Clinicians - 32		
	Mastery	Percentage
Responses (8 out of 10)	26	81%
Responses (7 out of 10)	6	19%

Table 3

Frequency of Responses for Each Item

Total Number of Clinicians - 32			
Item	Correct	Incorrect	Accuracy Percentage
1	32	0	100%
2	32	0	100%
3	26	6	81%
4	32	0	100%

Table 3 (Continues)

Item	Correct	Incorrect	Accuracy Percentage
5	32	0	100%
6	29	4	90%
7	26	6	81%
8	26	6	81%
9	26	6	81%
10	26	6	81%

Figure 1 provides an illustration of the above correct responses for each item.

Objective 2, as stated in Chapter III, projected for the 32 clinicians to decrease the number of inappropriate referrals by their evaluations and recommendations meeting 90 percent of the criteria on the Evaluation Review Instrument. By the end of the eight month period no evaluations were received by the Special Education Department from the clinicians pertinent to Learning Disabled. Therefore Objective 2 was not measured. However, the instrument is presently utilized to monitor evaluations received from counties within and outside the writer's state. Evaluations will be monitored during the 1990-91 academic school year utilizing the Evaluation Review Instrument. Verbal recommendations were received from clinicians by way of parents for the Special Education Department to conduct

diagnostic evaluations on specific children who appeared to demonstrate Learning Difficulties. These verbal recommendations, even though they appeared appropriate, could not be measured because they were obtained from parents. Specifically, no documented recommendations were received from the targeted population - clinicians.

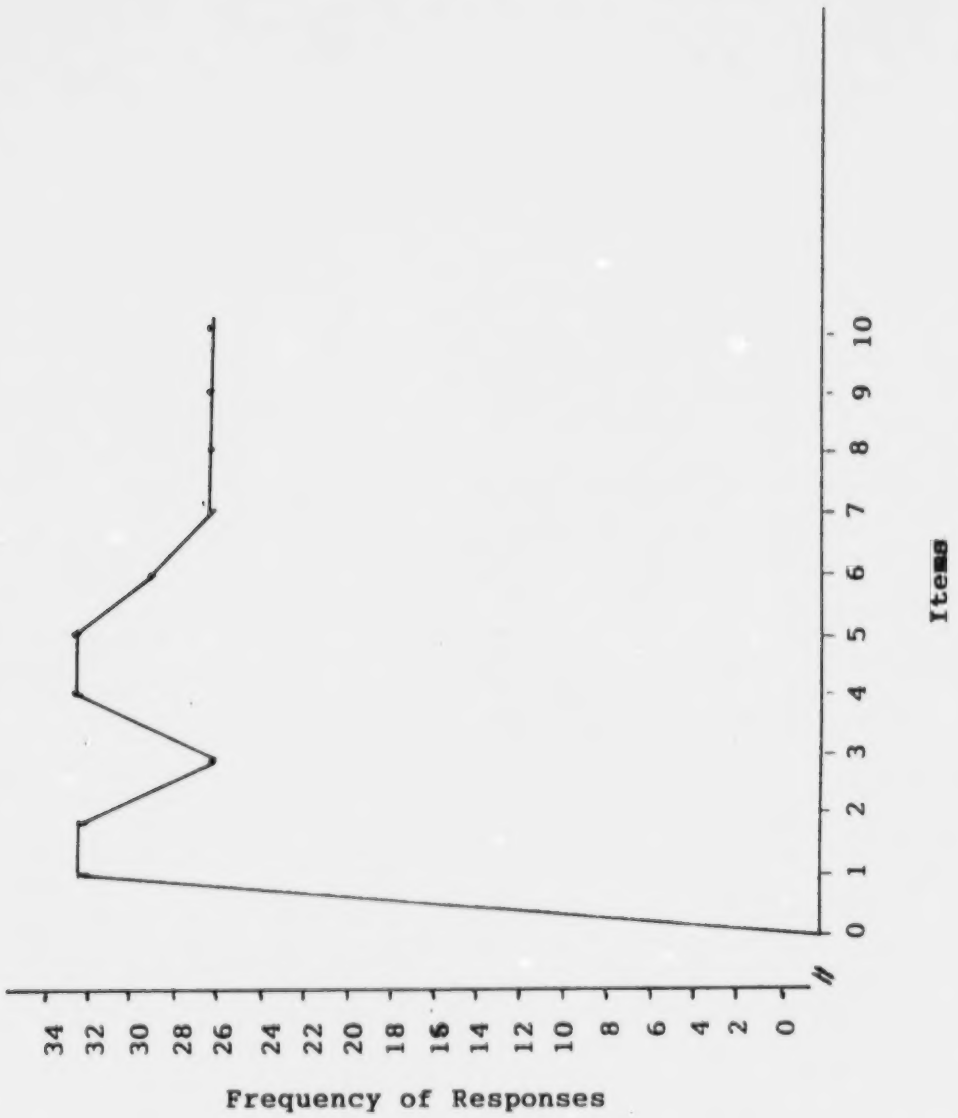

Figure 1: Frequency Distribution of Correct Response for each Item

Conclusion

An interpretation of the data suggests that Objective 1 was met, indicating that the goal of increasing the private sector's knowledge regarding criteria for Learning Disabled. The results confirmed the expectation that clinicians recognized the distinction between criteria for Learning Disabled and deficits associated with Learning Disabled.

The goal of reducing the number of inappropriate evaluations and recommendations to the Special Education Department from the private sector, as stated in Objective 2, is questioned. One could interpret the verbal recommendations received from the parents as meeting the objective because all recommendations appeared appropriate. Since the number of verbal recommendations were not recorded, no sound conclusion can be reached regarding Objective 2. In retrospect, because clinicians requested a copy of the Special Education Assessment Instrument for Learning Disabled for their future use, the writer should have prepared in advance a sample with the correct responses. In the writer's professional opinion, because of this request, clinicians will be more likely to adhere to the criteria for Learning Disabled in their evaluation and recommendations.

In the literature review, it is evident that others have met with positive results in utilizing solution strategies similar to those developed by the writer. For example,

Silver (1987), Mirsky (1988) and News Digest (1988) presented evidence of the target populations' improved awareness of criteria for Learning Disabled. Also, utilization of a pamphlet, brochure or newsletter by Mirsky (1988) and News Digest (1985) produced a desired outcome.

Since Objective I was met with positive results, Practical implications indicate that the private sector is aware that they must communicate with the Special Education Department in order to meet the needs of children with Learning Difficulties. Another implication is that the pamphlets provided information in order for the private sector and parents to enhance their communication skills with the Special Education Department. In essence, all parties will speak the same language.

One unanticipated outcome was the interest generated in the nurses and office assistants in the pediatricians' offices, evidenced by their requesting additional pamphlets. This interest is an indication that nurses and office assistants will share these pamphlets with their friends and neighbors, thus, further bridging the communication gap among the general population.

Based on the evidence gathered from the data presented in the Results Section, the writer concludes that the private sector acquired an increased knowledge regarding criteria for Learning Disabled and deficits associated with

Learning Disabled. Consequently, this practicum has been successful in bridging the communication gap between the private sector and the Special Education Department.

Recommendations

If others were to replicate this practicum, the writer's suggestions are (1) implement during the springs and summer months, (2) incorporate into the Evaluation Review Instrument a section for Verbal Recommendations and include **type** and **from whom**, and (3) use consultation strategies on an individual basis in order to stimulate unconditional verbal interaction.

As requested by the private sector, this practicum will be conducted for parents and offered to private schools and service clubs.

Dissemination

A copy of the practicum was made for the Director of Special Education. Copies of the pamphlets will be disseminated at schools throughout the county.

The coordinator and members of Cluster 31 will be presented a copy of the abstract.

This practicum will be submitted to the National Association of School Social Workers.

The writer was approached by colleagues to co-sponsor workshops in order to disseminate the pamphlets to teachers and parents. Also, in conjunction with the City Court, the writer will submit a grant to research the effect of Attention Deficit Hyperactive Disorder on Juvenile Delinquency.

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APPENDIX A

PERMISSION LETTER

Permission to Include Forms Developed by the
County Special Education Department
in the Practicum Report

Maxine Desselle has permission to include copies of forms and instruments developed by the Special Education Department in her Practicum Report.

Aaron Washington
Director of Special Education

APPENDIX B

JOB DESCRIPTION: SOCIAL WORKER

Social Worker

Qualifications: 46

Meet all applicable Standards for State Certification of School Personnel as prescribed in Paragraph 295 of Act 754 regulations.

Reports to: Director of Special Education and Coordinator of Special Education

Supervises: Client cases that are assigned

Job Goal:

The social worker shall be directly responsible to the Director of the Pupil Appraisal Center. He is to identify problems of exceptional children from the standpoint of home environment, physical, and emotional development where appropriate. The social worker shall make recommendations to school personnel, parent or guardian, and other agencies involved in working with the child.

Duties:

1. Secure pertinent information about the child referred, such as birth, physical, health, social and emotional development.

2. Identify the child's problems as seen by the parent or guardian. This should include problems relating to school, home, health, and social factors.

3. Identify the child's problems as seen by the school. This should include all academic and behavioral problems.

4. Through approved testing materials and observations, the social worker shall determine the child's level of functioning from the standpoint of emotional and social development.

5. Review all materials and make appropriate recommendations to assist the child with his problems.

6. Interpret findings and recommendations to parents or guardian, school personnel, and other agencies involved. A written summary of the diagnosis and recommendations will also be provided.

7. Assist in writing an Individual Education Plan whenever appropriate.

8. Assist Parish Placement Committee whenever appropriate.

9. Keep case material confidential.

10. Assist school personnel and parents with necessary help in order to carry out recommendations.

11. Utilize all available material, equipment, and facilities frequently in the teaching process to help the child assess.

12. Maintain accurate data on children, teachers, parents, and programs worked with.

13. Execute all policies of the school Board as directed by the handbook.

14. Care for all school properties, physical facilities, and industrial equipment used in helping teachers and parents.

15. Carefully document all activities including mileage, cases assessed, programs given, parents, school and gencies contacted.

16. Attend in-service workshops as mandated by the local policies as legislative acts as evidenced by attendance.

17. Participate in self-developmental activities such as, active membership in professional organizations, attendance at meetings, workshops, conventions, etc., whenever possible and continuously upgrading the position of the assessment person.

18. Promote the educational process as evidenced by the sharing of ideas and materials with other staff members.

19. Work in professional harmony with staff members and school administrators as evidenced by positive reports.

20. Use available means to keep abreast of trends, techniques, and teaching strategist as evidenced by teaching methods employed (Post graduate work is encouraged.)

21. Cooperate with parents and agencies for educationally related purposes as required when requested.

22. Give talks to civic and public organizations when requested to do so.

23. Strive to up-live the image of public education on a regular basis by keeping the general public informed of student and school programs as evidenced by the use of mass media, invitations, observations, etc.

24. Throughout the year, display concern for the vital interest of the community through special school activities.

25. The social worker will perform all other duties and responsibilities not listed as delegated by the Director of the Pupil Appraisal Center.

Terms of Employment: Twelve months

Evaluation: Criteria as established by School Board Policy

APPENDIX C

REFERRAL FORMS

☐ Initial ☐ Re-evaluation

PUPIL APPRAISAL SERVICES
CHILD IDENTIFICATION

STUDENT:

1. Name _____ (Last) _____ (First) _____ (Middle)
2. Residence _____ (No.) _____ (Street)
   _____ (City) _____ (State) _____ (Zip Code)
3. Telephone _____ (Area Code) _____ (Number)
4. Birthdate _____ (Month) _____ (Day) _____ (Year)
5. Age _____ (Years) _____ (Months)
6. Legal Guardian:
   - ☐ Parents
   - ☐ Mother
   - ☐ Father
   - ☐ Other _____ (Relationship)
7. Ethnic Background
   - ☐ Anglo (White)
   - ☐ Black
   - ☐ Native American Indian _____ (Tribe)
   - ☐ Hispanic
   - ☐ Asian–Pacific Islander
   - ☐ Other _____
8. Sex: ☐ Male ☐ Female
9. Primary Language _____
   Child's first acquired language
   _____
   Language most often spoken by student
   _____
   Language most often spoken in the home

PARENT(S)/GUARDIAN:

10. Name _____ (Last) _____ (First) _____ (Middle)
11. Address _____ (If different from above) (No.) _____ (Street)
    _____ (City) _____ (State) _____ (Zip Code)
12. Home Phone _____ (Area Code) _____ (Number)
    Work Phone _____ (Area Code) _____ (Number)
13. Live with child: ☐ Yes ☐ No
14. Marital Status:
    - ☐ Married ☐ Divorced
    - ☐ Separated ☐ Unknown

SCHOOL:

15. Name _____
16. Address _____
    _____
17. Telephone _____ (Area Code) _____ (Number)
18. _____ (Grade/Class)
19. Current Educational Program
    - ☐ None ☐ Regular ☐ Special
20. _____ (How long in present school)

REFERRED BY: (Optional Unless Teacher)

21. Name _____
22. Position _____
23. How long have you known student? _____
24. In what capacity? _____
    _____
    _____

25. Reasons for concern: _____
    _____
    _____
26. ☐ Other pertinent information attached.

I.D. # [redacted]

Current Placement:
- ☐ Regular Class
- ☐ Regular Class with Services
- ☐ Special Class
- ☐ Cooperative Program
- ☐ District No. 1
- ☐ Non-public Program
- ☐ Pre-school Program
- ☐ Day Care Program
- ☐ Not in School

Interpreter Needed: ☐ Yes
Surrogate parent needed: ☐ Yes

Initiated by: ON: _____ (Date)
- ☐ School
- ☐ Parent(s)
- ☐ Public Agency
- ☐ Private Agency (Specify)
- ☐ Other _____ (Specify)

How did you learn about this office? _____
_____

Notification of Identification
- ☐ Parent/Guardian
  Date _____
- ☐ Sp. Ed. Supervisor
  Date _____

Date of Screening
_____ To _____

Screening Decision:
- ☐ Regular Classroom
- ☐ Educational Assessment Program
- ☐ Individual Evaluation

Date of Decision _____
- ☐ Report Sent to Sp. Ed. Supervisor
  Date _____
- ☐ Report to Parents
  Date _____

Child Search Coordinator or Designee
_____ (Signature)

EVALUATION FILE

SCHOOL BUILDING SCREENING

Student _____ (Last / First / Middle) Birthdate _____ (Month / Day / Year)

Parent _____ (Last / First) Teacher _____ Grade _____

Screening is a process of collecting and reviewing information about the physical, learning or behavior characteristics of individuals birth through 21 for the purpose of identifying those who are possibly exceptional.

A. REVIEW OF SENSORY SCREENING EDUCATIONAL.

DATE

Screening: (If no record, schedule immediate screening.) Complete the following:

Vision Results ☐ Normal ☐ At risk _____ Date of Screening ☐ Corrected _____

Hearing Results ☐ Normal ☐ At risk _____ Date of Screening ☐ Corrected _____

Academic Grade Progression: In each grade level block, specify: P (Pass), F (Fail), S (Social Promotion). There may be more than one letter in a block.

Promotion													
GRADE LEVELS	K	1	2	3	4	5	6	7	8	9	10	11	12

2. Academic Performance: List the last achievement test scores recorded for student. Give results of Statewide Assessment Test. List the final report card grades for the last two years of school attendance and grades received so far this year.

a. Date of Testing _____

Name of Test _____

	% Tile	Stanine	Grade Level
Total Reading			
Total Language			
Total Math			
Science			
Social Studies			

b. Statewide Assessment Test

Date of Testing _____

Reading _____

Math _____

Writing _____

c. Report Card Grades

	PREVIOUS YEAR		PRESENT YEAR
Total Reading			
Total Language			
Total Math			
Science			
Social Studies			
Days Absent			

If prior evaluation, Date _____ Attach Report of Evaluation or Case Number and Current IEP.

B. REVIEW OF ACADEMIC AND SOCIAL PERFORMANCE, LANGUAGE, AND COMMUNICATIVE SKILLS AND MOTOR PROFICIENCY BY THE STUDENT'S TEACHER(S).

Functional Levels: Plot your judgement of the grade level where student is functioning in your classroom. Connect the plotted points. Indicate the student's actual grade placement by drawing a horizontal line across the graph. Departmentalized teachers might find it beneficial to confer with child's other teachers.

	Word Attack Skills	Reading Vocabulary	Oral Reading Comprehension	Silent Reading Comprehension	Listening Comprehension	Oral Expression	Written Language	Use of References	Spelling	Handwriting	Mathematics Facts	Math Skills/Computation	Math Word Problems	Science Concepts	Social Studies Concepts	Map/Graph Skills	Problem Solving Skills
14																	
13																	
12																	
11																	
10																	
9																	
8																	
7																	
6																	
5																	
4																	
3																	
2																	
1																	
K																	
PK																	

Attach and date any pertinent samples of student's work. (Check the appropriate box if attachments are included).

☐ Additional Information ☐ Work Samples

4. Student Evaluation. Please check the column to indicate how the student rates most of the time according to the following scale:

1. Poor 3. Average 4. Above Averag
2. Below Average 5. Excellen

	1	2	3	4	5
Gross Motor Development					
Fine Motor Development					
Motor Coordination					
Creativity					
Attention Span					
Work/Study Habits					
Self Motivation					
Attitude Toward School					
Observance of School Rules					
Peer Group Participation					
Attitude Toward Peers					
Leadership					
Self-Concept					
Maturity (For Age)					
Reaction To Stress					
Attitude Toward Adults					
Politeness					
Body Care					
Clothing Care					
Safety Awareness					
Responsibility					
Family Relationships					

COPY 1 & COPY 2 - Stay in Cumulative Folder if Regular Education Program is Checked

COPY 2 - Cumulative Folder if Referred to Director of Special Education is Checked

COPY 1 - Special Education Folder if Referred to Director of Special Education is Checked

COPY 1

APPENDIX D

EVALUATION TIMELINES

J. Evaluation Timelines

1. There shall be a period of no more than 10 operational days from the date of the receipt of referral for an individual evaluation of an identified student by pupil appraisal to the date when the request is made for parental approval to conduct the individual evaluation.

2. The evaluation report must be completed and disseminated within 60 operational days of receipt of parental approval unless a justified extension of time is required as specified.

3. An extension of time of no more than 30 operational days is permitted when:

   a. The evaluation coordinator and the student's teacher(s) determine that the pupil appraisal assessment program should be extended.

   b. Unusual circumstances, such as illness of the student, illness of a member of the student's family, or of the pupil appraisal person working with the student, interrupt the completion of the individual evaluation.

   c. The student has received an individual evaluation within the past three years, but the report has not yet been received by pupil appraisal services.

4. An extension of time of no more than 60 operational days is permitted when:

   a. Specialized diagnostic assessment and/or medical assessment services not available in the school system are necessary for the completion of the individual evaluation.

   b. Natural disaster or catastrophe interrupts the completion of the evaluation. Such extensions must have prior approval from the State Department of Education, Office of Special Educational Services.

5. The maximal number of days of the extension described in 3 and 4 above shall not exceed the duration of the circumstance(s) necessitating the extensions.

6. Whenever formal parental approval for the initial evaluation of a student who is suspected of being exceptional is received within 30 operational days of the end of the school year, the evaluation coordinator may postpone the initiation of the evaluation to the first week of the next school year, or initiate the evaluation if it appears that the requirements of §436 of the Act 754 Regulations can be met. If the decision is to postpone or if the process, once initiated, cannot be completed, parents shall be given full and effective notice. If the process once initiated cannot be completed prior to the end of the school year, the evaluation may be completed during the next school year, as long as the total time required for the completion of the evaluation does not exceed 60 operational days, excluding that period during the summer when the regular school program is not in session.

7. Whenever the evaluation process initiated for any student within 59 operational days of the end of the school year cannot be completed prior to the end of the school year, the completion of the evaluation may be postponed until the next school year as long as the total time for the completion of the evaluation does not exceed 60 operational days, excluding that period during the summer when the regular school program is not in session.

8. Any extensions of the individual evaluation timeline must be explained and documented in the individual evaluation report.

IV. INTERIM PLACEMENTS FOR EVALUATION PURPOSES

Students who have been receiving special education in another state or school system within the State and children who possess a severe, low-incidence impairment documented by a qualified professional may be initially enrolled in a special education program concurrent with the completion of the evaluation according to the requirements of Bulletin 1508. The enrollment shall occur only after:

1. Approval by the supervisor of special education,

2. A review of all evaluation information by pupil appraisal personnel,

3. The development of an interim IEP in accordance with §440-446 of Act 754 Regulations, and

4. Obtaining formal parental approval for the temporary placement.

The duration of time for the completion of the evaluation and interim placement shall not exceed the evaluation timelines specified in section III "J", with the initial IEP developed within 30 calendar days of the completion of the evaluation.

APPENDIX E

DEFINITION: EXCEPTIONALITY

DEFINITION OF EXCEPTIONAL

For a child to be considered an exceptional child under the Regulations implementing Act 754, two conditions must exist.

First, the assessment data must indicate that:

1. An impairment is present, or

2. A requisite is present, such as exceptionally high abilities.

Second, an assessment of the current and past learning environment and the educational progress of the child must demonstrate a need for special educational services.

Only when both of the above are true is the child considered exceptional. Misclassification can occur in evaluating children by assuming that:

1. All impaired children need special educational services, or

2. All children with educational needs are exceptional.

APPENDIX F

NEWSLETTER

ARE YOU LOOKING FORWARD TO ANOTHER YEAR OF:

"Can't he stop talking for 5 minutes?"

"He's always moving, I can't make him sit still."

"She just doesn't pay attention, never follows directions."

"Good Lord, what will he do next!"

OR MAYBE YOU HAVE BEEN SAYING:

"Will she <u>ever</u> get it all together?"

"He's <u>so</u> good and he tries <u>so</u> hard, why can't he learn?"

"He doesn't seem to have <u>any</u> friends."

IF SO, MAYBE THIS CAN HELP. . . . . .

Even though we just described what sounds like "problem" children (sometimes labeled as immaturity by educators); they may be children with a hidden handicap known as **ATTENTION DEFICIT DISORDER AND/OR LEARNING DISABILITY (ADD/LD).**

WHAT IS ATTENTION DEFICIT DISORDER/LEARNING DISABILITY?

ADD/LD is the name given to the condition in children, teenagers, and adults when they show poor attention as well as impulsivity in their day-to-day behavior. Children who exhibit certain signs--notably impulsivity, short attention span, disorganization, emotional outbursts, distractibility, and hyperactivity--are children with ADD/LD.

These children may be **overactive** (hyperactive), **underactive** (hypoactive) or **occasionally mixed**; that is, both hyperactive and hypoactive, but not consistently one or the other.

SIGNS OF ATTENTION DEFICIT DISORDER/LEARNING DISABILITY

Inattention:

a) often fails to finish what he starts
b) doesn't seem to listen
c) easily distracted
d) has difficulty concentrating or paying attention
e) doesn't stick with a play activity

Impulsivity:

a) often acts without thinking and later feels sorry
b) shifts excessively from one activity to another
c) has difficulty organizing work
d) needs a lot of supervision
e) speaks out in class
f) doesn't wait to take turns in games or groups

Hyperactivity:

a) runs about or climbs on things excessively
b) can't sit still and is fidgety
c) has difficulty staying in his seat and bothers classmates
d) excessive activity during sleep and other sleep problems
e) always on the "go" and acts as if "driven"

Emotional instability:

a) angry outbursts
b) social loner
c) blames others for problems
d) fights with others quickly
e) very sensitive to criticism

ADD/LD is not a problem that can be "cured" but rather treated and controlled. If you notice some signs in a child, start with a parent-teacher conference and talk about further course of action.

Successful treatment of ADD/LD involves a combination of understanding, counseling, educational intervention, and medication.

APPENDIX G

ELIGIBILITY REQUIREMENTS

LEARNING DISABLED

LEARNING DISABLED

I. DEFINITION

Learning Disabled means severe and unique learning problems as a result of significant difficulties in the acquisition, organization, or expression of specific academic skills or concepts. These learning problems are typically manifested in school functioning as significantly poor performance in such areas as reading, writing, spelling, arithmetic reasoning or calculation, oral expression or comprehension, or the acquisition of basic concepts.

The term includes such conditions as attentional deficit, perceptual handicaps, process disorders, minimal brain dysfunction, brain injury, dyslexia, developmental aphasia, or sensory-motor dysfunction, when consistent with these criteria.

The term does not include students who have learning problems which are primarily the result of visual, hearing, or motoric handicaps, mental retardation, a behavior disorder, or environmental, cultural, or economic disadvantage.

II. CRITERIA FOR ELIGIBILITY

Criteria A through G must all be met.

A. The learning problems are not due primarily to such factors as:

a. —lack of educational opportunity,
b. — emotional stress in the home or school,
c. —difficulty adjusting to school,
d. -curricular change or temporary crisis situations,
e. -other handicapping conditions,
f. environmental, cultural, or economic disadvantage, and/or
g. lack of motivation.

B. There must be evidence that the student, after receiving supportive and remedial regular educational assistance, still exhibits a learning disability consistent with the definition. Students eligible for compensatory or remedial education programs shall receive assistance in these programs prior to being considered for special educational services.

C. There must be evidence that the student, after receiving services in the Pupil Appraisal Assessment Program specific to the identified learning problems, exhibits a learning disability consistent with the definition. This evidence shall include, at a minimum, the results of the systematic measurement of the identified specific learning problems, conducted according to the procedures for evaluation, which indicate that the student's learning abilities are significantly impaired with respect to those of nonhandicapped students.

D. There must be evidence of a severe discrepancy between achievement and ability as demonstrated by a difference of at least one standard deviation between the student's strongest and weakest performance in academic areas described as follows:

1. A relative academic strength as demonstrated by performance no more than one standard deviation below the mean in grades 3 through 12 or one half standard deviation below the mean in grades K through 2 for the grade level appropriate for the child's chronological age in one or more of the areas listed under 2 below. The relative academic strength must, in addition, be at least one standard deviation higher than the lowest academic area identified in 2 below. The standard error of measurement may be considered in individual cases.

2. An academic deficit or deficits, as demonstrated by performance greater than one and one half standard deviations below the mean in grades K through 2, or two standard deviations below the mean in grades 3 through 12 for the grade level appropriate for the student's chronological age in one or more of the following areas. The standard error of measurement may be considered in individual cases.

   a. Reading recognition (basic reading skill),

   b. Reading comprehension,

   c. Math calculations,

   d. Math reasoning,

   e. Oral expression,

   f. Listening comprehension,

   g. Written expression (e.g., spelling), and

h. Other age-appropriate developmental skill areas when more appropriate for kindergarten students (e.g., preacademic skills).

III. PROCEDURE FOR SCREENING

General Screening Procedures shall be followed.

IV. PROCEDURES FOR EVALUATION

A. The Pupil Appraisal Assessment Program shall be conducted for students suspected of being Learning Disabled and shall include:

1. Sensory screening, if not previously conducted.

2. A review of the student's educational, social, and medical history, including the attendance record.

3. An interview with the student.

4. An interview with the student's teacher in order to specify and behaviorally define the areas of concern, determine the teacher's expectations for the student and class, and clarify any previous interventions.

5. A family interview conducted by a social worker or other appropriate pupil appraisal staff member to determine the impact of social, cultural, developmental, emotional, and/or health factors on the student's difficulties. The family interview should address such additional factors as:

   a. The parent's perception of the problem behavior;

   b. The expectations of the parents for the student in the home and school environments;

   c. Parental efforts to deal with the problem behavior at home and/or through community service contact;

   d. A determination of the student's strengths and weaknesses, relationships with peers and siblings, self-concept, and achievement motivation as perceived by the family; and

   e. Clarification of educational history information including attendance and other concerns of evaluation team members.

APPENDIX H

ELIGIBILITY REQUIREMENTS

ATTENTION DEFICIT DISORDER

DSM III - R

DSM III-R DEFINITION OF ATTENTION-DEFICIT HYPERACTIVITY DISORDER

Note: Consider a criterion met only if the behavior is considerably more frequent than that of most people of the same mental age.

A. A disturbance of at least six months during which at least eight of the following are present:

(1) often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)

(2) has difficulty remaining seated when required to do so

(3) is easily distracted by extraneous stimuli

(4) has difficulty awaiting turn in games or group situations

(5) often blurts out answers to questions before they have been completed

(6) has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension), e.g., fails to finish chores

(7) has difficulty sustaining attention in tasks or play activities

(8) often shifts from one uncompleted activity to another

(9) has difficulty playing quietly

(10) often talks excessively

(11) often interrupts or intrudes on others, e,g., butts into other children's games

(12) often does not seem to listen to what is being said to him or her

(13) often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, assignments)

(14) often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking

Note: The above items are listed in descending order of discriminating power based on data from a national field trial of the DSM-III-R criteria for Disruptive Behavior Disorders.

B. Onset before the age of seven.

C. Does not meet the criteria for a Pervasive Developmental Disorder.

CRITERIA FOR SEVERITY OF ATTENTION-DEFICIT HYPERACTIVITY DISORDER

Mild: Few, if any, symptoms in excess of those required to make the diagnosis and only minimal or no impairment in school and social functioning.

Moderate: Symptoms or functional impairment intermediate between "mild" and "severe."

Severe: Many symptoms in excess of those required to make the diagnosis and significant and pervasive impairment in functioning at home and school and with peers.

The new DSM also contains a residual category (**Undifferentiated Attention-deficit Disorder**) for disturbances in which the predominant feature is the persistence of developmentally inappropriate and marked inattention that is not a symptom of another disorder such as retardation or a disorganized, chaotic environment.

Diagnostic and Statistical Manual (Volume III-Revised): pages 52-53

APPENDIX I

SPECIAL EDUCATION ASSESSMENT INSTRUMENT

SPECIAL EDUCATION ASSESSMENT INSTRUMENT

FOR LEARNING DISABLED

PLEASE CHECK APPROPRIATE COLUMN

	Criteria for L.D.	Deficits Associated with L.D.
1. Poor listening comprehension		
2. Achievement Discrepancy		
a. Written expression		
b. Basic reading skills and comprehension		
c. Math calculation and/or reasoning skills.		
3. Poor oral expression		
4. Hyperactivity		
5. Ability discrepancy on I.Q. test.		
a. Verbal (low)		
b. Performance (high)		
6. Easily distracted		
7. Dyslexia		
8. Inability to focus, sustain and organize attention.		
9. Easily frustrated and impulsive		
10. Difficulty following oral and written instructions.		

Developed by Maxine Desselle, BCSW - 1989

APPENDIX J

EVALUATION REVIEW INSTRUMENT

EVALUATION REVIEW INSTRUMENT

LEARNING DISABLED

1. **Psychological Assessment**

   Verbal_____

   Performance_____

   Full Scale_____

2. **Educational Assessment**

   Academic Strength

   Math_____ Reading_____

   Academic Deficit

   Math_____ Reading_____

3. **Family Interview**

4. **Speech/language Assessment**

5. **Sensory Screening**

Deficiencies that Prevent Compliance

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

Developed by Maxine Desselle, BCSW - 1989

APPENDIX K

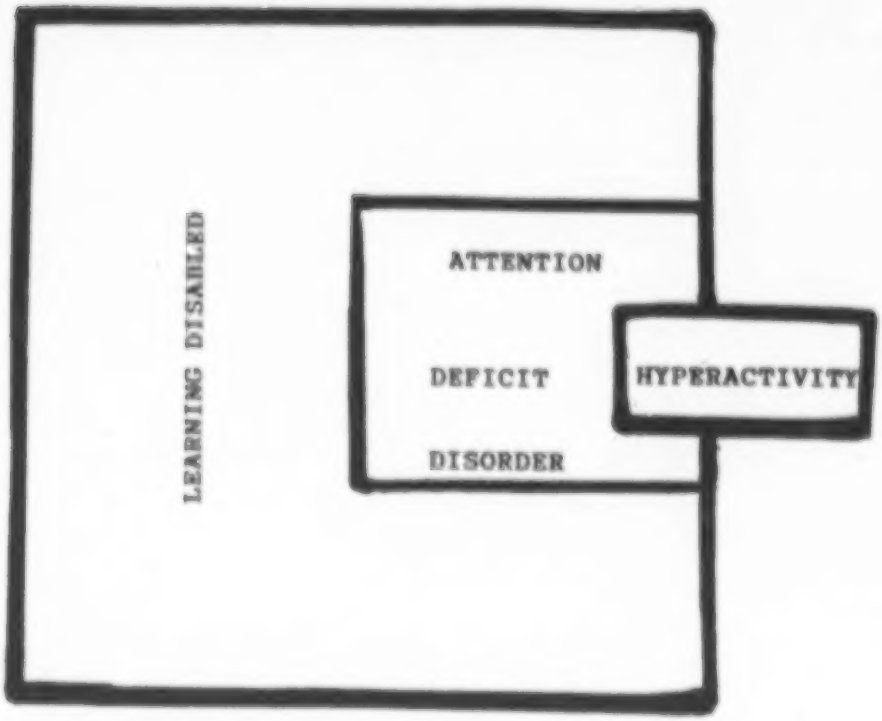
EXAMPLE OF PAMPHLET

LEARNING DISABILITIES

Attention Deficit Disorder

Learning Disabled

Hyperactivity



NOT ALL ADHD CHILDREN ARE LEARNING DISABLED

Enclosed Criteria for: Learning Disabled
Attention Deficit Disorder
Hyperactivity

TERMS DEFINED

Attention Deficit Disorder as defined by DSM III-R is a term identified by the American Psychiatric Association that describes children who display inappropriate attention and impulsivity. Onset usually before age 7.

Learning Disabled as defined by Public Law 94-142 is a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may result in imperfect ability to listen, think, speak, read, write, spell or to do mathematics. P.L. 94-142 dictatesthat L.D. should be applied **only** to children who have a **severe discrepancy** between academic achievement and intellectual ability in skills such as written expression, reading or mathematics.

Hyperactivity - children, despite normal intelligence are unmanageable at home and unsuccessful at school because they exhibit behaviors that are not age appropriate.

ATTENTION DEFICIT DISORDER

1. Inability to focus, sustain and organize attention.

2. Shifts from one uncompleted task to another.

3. Difficulty following oral and written instructions.

4. Difficulty organizing work.

5. Easily frustrated.

What Services are available?

No Special Education Services Available

1. Parent Support Group

2. Consult your local pediatrician

3. Seek tutoring services in your area.

LEARNING DISABLED

1. Good math vs. reading skills.

2. Good reading vs. math skills.

3. Poor written expression (spelling).

4. Low verbal score on I.Q.

5. High performance score on I.Q.

What Services are available?

Special Education

1. Resource class for L.D.

2. Itinerant Resource for L.D.

3. Self-contained class for L.D.

HYPERACTIVITY

1. Overly active since birth

2. Fights excessively.

3. Difficulty remaining seated when required.

4. Acts before thinking.

5. Difficulty waiting turns.

What Services are available?

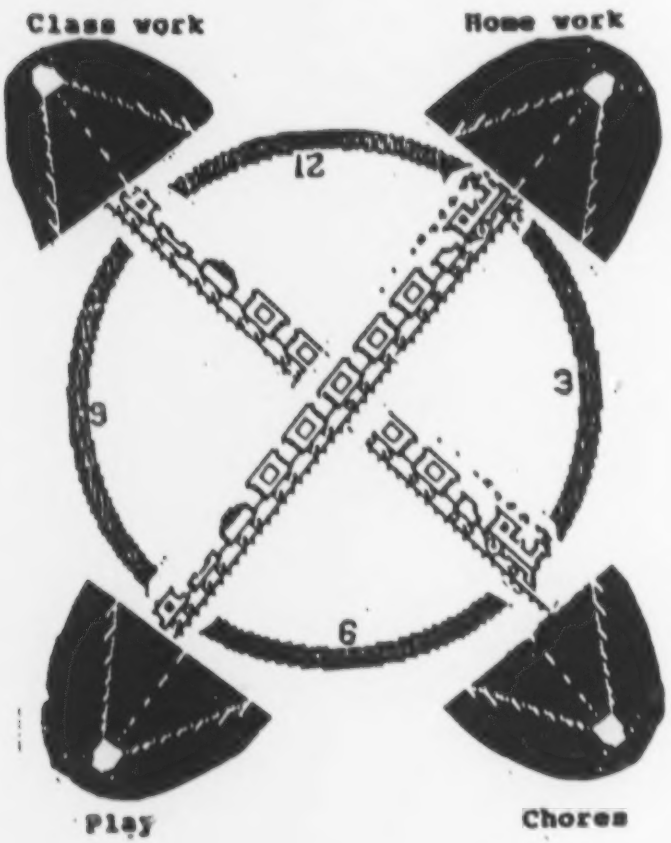
No Special Education Services Available

1. Parent Support Group

2. Consult your local pediatrician

3. Seek tutoring services in your area.

SOMETIMES CHILDREN
WITH
LEARNING DISABILITIES
GET LOST IN
THE TRACKS OF TIME.



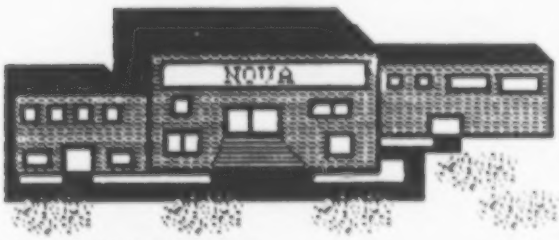
APPENDIX L

WORKSHOP NEWSLETTER

ATTENTION DEFICIT HYPERACTIVE DISORDER

WORKSHOP

PRESENTED BY: MAXINE DESSELLE, BCSW
NOVA UNIVERSITY

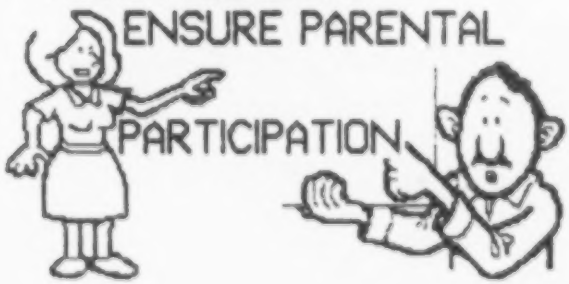


REACTIONS

NOT ALL ADHD CHILDREN ARE LEARNING DISABLED!!!!!!!!!!!!!

SUGGESTIONS WANTED

VOLUNTEERS TO ENSURE PARENTAL PARTICIPATION



CHILDREN WITH ADHD

APPEAR CLUMSY.

SOMETIMES CHILDREN WITH ADHD GET LOST IN THE TRACKS OF TIME.

ONE MOTHER DESCRIBED HER CHILD AS A "DISASTER WAITING TO HAPPEN"